Montana
2015 Health Insurance Training for Assistors

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MONTANA COMMISSIONER of SECURITIES AND INSURANCE
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2014 Enrollment Analysis: Successes

- In May 2014, CSI completed an insurer enrollment survey of the individual and small employer group markets, which produced the following results:**
  - Between January 1 and May 1, 2014, enrollment in the individual market grew by 26,429 covered lives, compared to enrollment on December 31, 2013, an increase of 54.5%
  - During the same time period, the small employer group market decreased by an estimated 10,306, a decrease of 19.1%
    - CSI estimates that at least half of that number moved to self-funded MEWA's and the remainder to the individual market
  - The net gain in traditional Medicaid and Healthy Montana Kids (HMK) enrollment during that time period was 8,739

Enrollment Analysis: Successes (cont.)

- CSI estimates that approximately 30,000 previously uncovered individuals gained coverage between January and May 2014. The estimate of uninsured in Montana was 195,000 (approx. 20%)
- The uninsured number has been reduced by 15.4%, reducing the overall uninsured rate to 16.9%
- The number of individuals estimated to be in the "Medicaid gap" is at least 50,000, according to the Montana Department of Public Health and Human Services (DPHHS)**

**Some national estimates show Montana's previous uninsured rate at closer to 22% and current uninsured rate at 17.65%.

What do 2015 plans look like?

Look for:

- Prescription drugs cost-sharing
- Provider and mental health office visits-co-payments vs. coinsurance
- What can the consumer afford?
  - The premium is not the only factor
- Maximum out-of-pocket: (in 2015 - $6,600 for an individual and $13,200 for a family) – watch out for HSA compatible

Glossary of Terms

- **Cost-sharing** – Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include *deductibles*, *coinsurance* and *co-payments*. *Balance-billed* charges from *out-of-network physicians* are not considered cost-sharing.
- **Deductible** – A dollar amount that a patient must pay for health care services each year before the insurer will begin paying certain claims under a policy. Some health plans do not apply the deductible to certain kinds of services, such as provider office visits.

Glossary of Terms

- **Out-of-pocket maximum** - An annual limitation on all *cost-sharing* for which patients are responsible under a health insurance plan. This limit does not apply to *premiums*, *balance-billed* charges from out-of-network health care providers or services that are not covered by the plan. The ACA limits the maximum out-of-pocket to $6,600 per individual and $13,200 per family in 2015. These amounts will be adjusted annually to account for the growth of health insurance *premiums*.
- **Coinsurance** - A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy, usually after the deductible is applied
- **Co-payment** - A flat-dollar amount which a patient must pay when visiting a health care provider, usually before the deductible is applied

Overview of Plan Comparison Chart

- Preventive services –not all are $0
- Emergency Room services—additional cost-sharing imposed
  - It is important for consumers to understand what an ***emergency medical condition*** is - don't use the ER unless you are certain.
  - Emergency Medical Condition: "The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A "prudent layperson" standard is applied."
  - Use urgent care whenever possible.
- All this cost-sharing is IN-NETWORK—OUT-OF-NETWORK is often four times higher
- Out-of-network cost sharing is "tracked separately." It has a separate and much higher maximum out-of-pocket. Look to the SBC to see the out-of-network cost-sharing.

Plan Comparison Chart (cont.)

- Deductible and coinsurance always apply to in-patient services, but also to out-patient surgery, lab and diagnostic tests, emergency room services, some mental health out-patient services and sometimes drugs.
- In addition, there are sometimes "special" deductibles and co-payments for certain services that insurers want to discourage, such as emergency room. These charges can be in addition to the regular deductible and coinsurance.
- However, none of these charges can add up to more than the maximum out-of-pocket.
- The rate charts for all these plans are on our website.

New Insurer – Assurant (TIME)

- Time has two different plan designs.
  - Plan 2 is sold in all four metal tiers. Plan 2 has post-deductible coinsurance in all metal levels for prescription drugs
  - Plan 1 is sold in silver and bronze only, but the silver plan has pre-deductible copayment amounts
- Time has two provider networks, but only the ASA (Aetna) network is available in the Marketplace.
  - Make sure you are looking at the right network

PacificSource

- PacificSource has two networks: SmartHealth and PSN. SmartHealth is a more limited network, primarily in Billings and Missoula. The PSN plans offer a broader network
- PacificSource has two product lines for each network: Balance and Value
  - All of the Balance plans have pre-deductible, flat dollar co-payments for office visits, including mental health, and for all prescription drug tiers
  - All Value plans have all services subject to a deductible before any payments are made by the insurer. However, the maximum out-of-pocket is lower
    - For instance, you can choose a silver plan with a $3,000 deductible and $3,000 maximum out-of-pocket
- Both the SmartHealth and PSN networks have a Value and Balance option

Montana Health Coop (MHC)

- Montana Health Coop (MHC) has two networks: Access and Connected Care
- Connected Care is the more limited network, mainly in Billings and Missoula
  - Only Connected Care offers a platinum plan
- MHC has three product designs: Access, Connected Care and Connected Care "Plus"
  - Connected Care "Plus" is a deductible-only plan (including for drugs)—no coinsurance or co-payments, but with a lower maximum out-of-pocket
  - For instance, in the gold Connected Care "Plus" the consumer would pay $2,100 deductible before ANY services are covered (except mandated preventive); however, the maximum out-of-pocket is also $2,100

**What is a Co-op? - A non-profit health insurer that is member-owned and operated. The ACA created co-ops and provided grants and loans to assist in the "start up" of these new non-profits.

Blue Cross Blue Shield of MT (HCSC)

- BCBSMT (HCSC) labels their plans, "Blue Preferred 1 through 6"
- BCBSMT does not offer a platinum option, but has two products (benefit designs) in the 3 other metal levels, starting with I and 2 in the gold tier
- Preferred plans 1, 4, and 6 have higher deductibles, but lower max OOP
- Silver and gold tiers for both products have pre-deductible co-payments for prescription drugs and provider visits
  - One bronze plan (5) has a co-payment for doctor and mental health visits, but not for drugs

Things a Consumer Should Consider When Choosing a Plan

- Do I have health issues that may result in costly or frequent claims during the coming year?
- How much cost-sharing can I afford?
  - Do I have $6,000 in a savings account to cover the cost of higher deductible health plan?
  - Is it better for me to choose a plan with a lower deductible and more up-front costs paid, at least in part?
  - Many plan options have co-payments for office visits that are applied "pre-deductible."
- Check the provider network for each insurer.
  - Are there enough primary care physicians or specialists available in my area? Do they take new patients?
  - Is my doctor in-network?
  - Is my town's hospital in-network?

Considerations When Choosing a Plan (cont.)

- Do I need access to a high cost or specialty tier drugs?
  - If so, does this plan include that drug in their formulary? What is the cost-sharing for that drug?
- Do I travel out-of-state a lot or have family members that live out-of-state?
  - If so, evaluate that plan's "out-of-state" network.

**OUT-OF-NETWORK COST SHARING IS VERY HIGH

- Consumers can link to the insurer's "Summary of Benefits and Coverage" to obtain more detail about cost-sharing arrangements in each plan
- In addition, www.montanahealthanswers.com now has a plan cost-sharing comparison chart for all Marketplace plans

Not all Silver Plans are Created Equal

- The ACA requires individual and small employer group health plans to be placed in "metal tiers" of the same actuarial value: platinum, gold, silver and bronze
- However, there are numerous different health plans offered by the same insurer in each metal tier, each with significantly different cost-sharing arrangements
  - For instance, deductibles in silver plans range from $1,500 to $6,000
- Higher deductibles may be combined with much lower other types of cost-sharing, such as coinsurance and co-payments
  - For some benefits, consumers pay only "pre-deductible" flat dollar co-payments, i.e. preventive services

Silver Plans (cont.)

- Usually co-payments are "pre-deductible"
- Consumers should evaluate all cost-sharing options carefully, so they understand how the plan works before they purchase it
- Consumers must be reminded to stay "in-network"
- The "Summary of Benefits and Coverage" can help with that understanding
- The "same" actuarial value does not mean standardized cost-sharing parameters

Network Adequacy Terms

- **Balance billing** - When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount. This is known as “balance billing”
- **Out-of-network provider** - A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization’s network (such as an HMO or PPO). Depending on the managed care organization’s rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider

Network Adequacy

- In Montana, a new network adequacy law went into effect October 1, 2013. Most "network-type" health insurance plans, including dental and vision, sold in Montana are "PPO" plans.
  - The consumer's cost-sharing (i.e. deductibles, coinsurance, co-payments and maximum out-of-pocket) is increased if he/she seeks coverage from "out-of-network" healthcare providers. Consumer cost-sharing is substantially reduced or even eliminated (for preventive services) if that consumer seeks healthcare services "in-network"
- The new law says that a provider network is "deemed" adequate if it includes 90 % of the hospitals and 80 % of the healthcare providers in the state
- Below that threshold percentage, the commissioner may "determine" a network to be adequate

Network Adequacy (cont.)

- Below that level, a maximum differential is applied: no more than a 25% cost-sharing difference that the consumer pays for out-of-network services
- The commissioner will disapprove a network plan as "misleading" if there is no viable network
- Cost-sharing differences between in and out-of-network are significant—as much as four times higher. Consumers should always check the insurer's list of in-network providers before they choose a health plan
- Many of the benefits of the ACA are based on "in-network" costs only

Always Look at the Drug Plan

- Does the consumer take numerous prescription drugs, or particularly high cost drugs?
- Can they afford to pay the entire deductible before receiving any help paying for their drugs?
- Every insurer in the silver tier and above has at least one plan option that has "pre-deductible" copayments in the drug plan
- There is always an "exception" process, in addition to regular internal and external appeal
  - May be expedited
- All drug plans are "managed" with tools such as "step therapy" and "tiering"
  - Drug plans described on montanahealthanswers.com

Glossary of Terms

- **Generic drugs** - A drug where the patent has expired and it is no longer available as "brand name." Generally the least expensive drug option. These are "tier one" drugs
- **Preferred drug** - A drug formulary is a regularly updated list of medications supported by current evidence-based medicine that encourages the use of safe, effective medications. Insurers often use the term "preferred drug" in their drug plans for these "brand name" drugs that are usually placed in "tier two"
- Formulary development also includes elements of affordability—the most cost effective or lower priced drugs. Different brand name drugs may do the same thing, but the pricing on one is better than another. Formularies are updated quarterly—and changes are often driven by cost
- **Non-preferred or non-formulary -** also brand name drugs - usually those that are more expensive than the preferred option, but treat the same illness or symptoms. Sometimes these drugs are also considered less effective or less safe

Glossary of Terms

- Physicians may justify access to non-formulary drugs when medically necessary
- Every drug plan has an "exception" process that allows the physician and the insured to approve the use of a different drug, but at the lower tier cost sharing
- **Specialty Tier drugs** - Non-generic, brand name drugs that are used to treat complex or chronic conditions that usually require close monitoring, such as MS, hepatitis, rheumatoid arthritis, cancer and others. These drugs may require special handling and may need to be dispensed through a specialty pharmacy. These drugs are very expensive—often thousands of dollars for a 30-day supply
- Drug plans usually require prior authorization for these drugs
- If authorization is denied, there is an exception process, followed by the normal internal and external appeal process

What consumers need to know when accessing their health plan coverage

- When making an appointment, confirm that the provider is in that insurer's network
- Preventive services may be $0 cost-sharing if:
  - The provider is "in-network"
  - The main purpose of the visit is to seek the preventive care
  - The preventive care has an A or B rating in the recognized medical guideline. When in doubt, check with your insurer
- There are NO pre-existing exclusionary periods for any covered services

Mental Health and Chemical Dependency

Individual and small group health insurance must include coverage for mental health and chemical dependency services:

- Behavioral health treatment, such as psychotherapy and counseling;
- Mental and behavioral health inpatient services; and
- Substance use disorder treatment.

Mental Health Parity

- The Mental Health Parity and Addiction Equity Act of 2008 requires health insurance companies to cover mental health the same as physical health
- Health insurance companies cannot place more restrictions on mental health treatment or addiction disorder benefits than the restrictions they apply to physical illness, generally
  - Also, cost-sharing cannot be higher
- If there are visit limits and co-pays on physical illness, mental health coverage may have comparable limits and cost-sharing. Costs for mental health care can't have a separate deductible
- This law originally only applied to large employer group health plans. However, Obamacare expanded this law to all individual and small group employer health plans beginning on January 1, 2014.

Mental Health Parity and Addiction Equity Act

- Requires group health plans and health insurers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or addiction disorder benefits are no more restrictive than what is applied to physical illness generally
- Consumers need to understand their rights in this area
  - The law is still new and claims are not always processed correctly
  - A visit to a counselor, such as an LCSW or LCPC or psychologist is generally the equivalent of an "provider visit" such as a physician, PA or APRN and the same cost sharing should apply; i.e. a co-payment

Mental Health Parity and Addiction Equity Act (cont.)

- Formerly (since 2008) this law applied to large employer group health plans only
- Since January 1, 2014, it also applies to all individual and small employer group health plans
- The dollar limits in the Montana insurance code for mental health and chemical dependency are preempted by operation of federal law

Pediatric Dental Benefits

- Dental and vision benefits for children under age 19 are a required part of the essential health benefit package
  - These benefits must be the same as those offered in the federal employee plan
- Lifetime and annual dollar limits cannot be applied to pediatric dental and vision benefits
  - A maximum out-of-pocket is established each year
- No health plans sold inside the Montana Marketplace offer embedded pediatric dental benefits—all are "9 ½ plans."
  - A "stand-alone" pediatric dental plan must be sold with the 9 ½ health plan in order to make the package complete
  - These plans are known as a certified stand-alone qualified dental plans (QDP)

Pediatric Dental Benefits

- There are numerous stand-alone dental plan options offered in the Marketplace. Sometimes those plans are combined with adult dental coverage, which are allowed to have annual dollar limits
- Pediatric dental must have a "high" (85 %) or "low" (70 %) actuarial value and offer a maximum out-of-pocket of $350/one child and $ 700/two or more children
  - This is a reduction from 2014 when it was ($700/$1,400)
- Pediatric dental rates may be "underwritten," which means that sometimes the rate shown is "guaranteed" (not subject to underwriting) and sometimes the rate is subject to change (underwritten)—the rate may go up after the application is evaluated by the QDP

Stand Alone Qualified Dental Plans (QDPs)

- Stand alone qualified dental plans (QDPs) may also be sold **"off exchange"**
  - "Off-exchange" QDPs must seek "reasonable assurance"
- The insurer must obtain "reasonable assurance" that the consumer will purchase a QDP before selling a health plan that does not contain pediatric dental
- This is an issue mostly for insurers
  - Consumers cannot be penalized for not buying it
  - Insurers can be penalized for not obtaining reasonable assurance
- In Montana, insurers are not allowed to "auto-enroll" anyone without their permission into a QDP
  - SEE THE COMMISSIONER'S BULLETIN on this issue at www.csi.mt.gov

Stand Alone Qualified Dental Plans (QDPs)

- None of our health plans include pediatric dental—it is all sold separately
- QDPs are available on and off the Marketplace
- None of QDPs sold in Montana have an "adequate" network
- The CSI has allowed two dental insurers to have a small cost-sharing differential between "in-network" and out-of-network services
- Consumers should be prepared to pay the out-of-network cost, because very few dentists will sign network contracts

Renewal Notices

- Montana made some modification to the renewal notices
- Most existing plans will be "auto-renewed" if people take no action and their tax credits will be continued at the same level
- Remind everyone to update their financial information on healthcare.gov, even if they are keeping the same plan
- Tell individuals who did not buy plans in the Marketplace last year that they may be eligible for tax credits if they go to healthcare.gov
- IMPORTANT***If an individual changes their health plan choice, they should notify their insurer, even though the Marketplace is supposed to do that

Problems with Documentation Verification Regarding Income or Citizenship Status

- Coverage may be terminated if citizenship documentation is not submitted or is inadequate
- Income documentation issues could result in loss of tax credits but should not result in loss of coverage
- Insurers in Montana still have a duty to provide adequate notice of termination or a change in premium.
- Report problems to the CSI

Protected Personal Information

- Social security numbers, personal financial information, protected health information and other identifying personal information may be exposed when an assister is helping an individual enroll in a health plan
- This kind of information, including even name and address and date of birth, is known as "protected personal information"—PPI
- Any person assisting with enrollment in the Marketplace has a legal duty to protect PPI

You Must Protect and Secure PPI

- There are various state and federal laws that require the protection of PPI. We are focusing on the Montana law
- Montana has adopted the Insurance Information and Protection Act (IIPPA), which complies with the federal minimum privacy protections contained in the Graham Leach Bliley Act (GLBA)
- This Act applies to Certified Application Counselors and Navigators, as well as insurance producers
- You may only disclose PPI to entities/individuals when it is required to complete an insurance transaction
- All other disclosures require a written authorization from the individual

Protected Personally Identifiable Information (PPI)

- Names
- Addresses
- Places of employment
- Incomes
- Credit histories
- Various account numbers
- Social security numbers
- Dates of birth
- Information contained on income tax returns
- Health information

Illegal Disclosure of PPI includes, but is not limited to:

- Careless disclosure: accidentally leaving PPI where unauthorized individuals can see it, including
  - Paper in a waste basket or on a desk
  - Leaving information visible on a computer terminal where others can see it
- Oversharing
  - Mentioning details of another individual's PPI in casual conversation with friends, family or neighbors
  - All privacy laws require that the "minimum necessary" information be disclosed only to those authorized to receive it. Do not share PPI, even with other Navigators, CAC's or producers, unless that person "needs to know" in order to carry out job duties.

Illegal Disclosure of PPI Includes, but is not limited to:

- The following are examples of failing to secure PPI:
  - Your laptop is stolen. It does not have appropriate safeguards and the PPI is compromised.
    - If there is any breach of computer security, that breach must be reported to all individuals whose PPI was compromised immediately, even if no misuse of that information has occurred. Law enforcement should be informed.
  - You leave file drawers or desk drawers containing PPI unlocked. You leave papers out in the open on your desk and others are able to view them such as janitors, repair persons, etc.
- Navigators and CAC's are not allowed to keep PPI in their possession any longer than it takes to successfully assist with the enrollment of that individual in Marketplace coverage. This information cannot be used for any other purpose.

Fraud and Intentional Misuse of PPI – Criminal Acts

- Intentional misuse
  - Using another individual's PPI for private gain is a crime, which will be prosecuted by the commissioner's office or other law enforcement
  - That crime can be punished by fines and jail sentences
- GUARD AGAINST FRAUD AT ALL TIMES
  - Certified assisters must report to the commissioner's office any suspected misuse of PPI, including information about individuals who "pose" as legitimate assisters and are not properly certified
- WARN INDIVIDUALS NOT TO GIVE THEIR PPI TO INDIVIDUALS WHO ARE NOT CERTIFIED ASSISTERS AND LISTED ON THE COMMISSIONER'S WEBSITE
  - Immediately report any suspicious activity to the CSI

Do not Engage in Unlicensed Activity

- Only licensed health insurance agents are allowed to "sell, solicit, or negotiate" insurance, which means that CAC's and navigators may NOT:
  - Receive compensation for "selling" a health plan,
  - "Urge a person to buy" a particular health plan, or
  - "Offer advice to a prospective purchaser concerning the substantive benefits, terms or conditions" of a particular health plan

Do not Engage in Unlicensed Activity

- CAC'S and Navigators may provide "enrollment assistance," which includes:
  - Helping a consumer navigate the Marketplace website, and
  - Assisting with completion of the uniform application that determines a person's eligibility for Medicaid, HMK, premium assistance tax credits or cost-sharing reductions.
- Beyond that, CAC's and Navigators may only explain the decision-making points that an individual should consider when choosing a plan
- CAC's and Navigators MAY NOT:
  - **Recommend certain health insurers or health plans over others**
  - Offer financial advice or tax advice, especially to employers

Consequences of Unlicensed Activity and Conflicts of Interest

- A person who acts as an insurance producer without a license (sells, solicits or negotiates insurance, even without compensation from an insurer), may be subject to significant fines imposed by the insurance commissioner, or even criminal penalties
- **Navigators and other types of assisters may not receive any compensation of <u>any</u> type of insurer. Such compensation creates a conflict of interest**
- Navigators who receive any kind of compensation from any type of insurer, including "in-kind" compensation, will have their Navigator license revoked

Student Health Insurance

- In general, all university students have access to a student plan—in fact, the terms of their enrollment requires them to have coverage
- Student health plan coverage is considered "individual" coverage, except that the rates can be different AND enrollment in the health plan is contingent upon maintaining student status
- An offer of student health plan coverage is NOT a barrier to receiving tax credits in the Marketplace
- Sometimes the Marketplace is cheaper than student plan coverage (which currently is at a "gold plan" level,) especially for students under age 21, OR if the student has income amounting 100% or more of FPL, OR if the individual prefers less generous coverage—bronze or even catastrophic coverage

Retiree Health Insurance

- Individuals who have retired before the age of 65 do not have to accept their retiree coverage and may enroll in the Marketplace and possibly receive tax credits instead
- For instance, the state of Montana retiree coverage is quite expensive and those retirees may consider Marketplace coverage
  - BUT the Marketplace coverage is different and may be less generous
  - State retirees have a one-year period that will allow them to "go back" to the state plan—after that they may not return, even after they turn 65
- The decision to switch can be complicated and involve financial decisions that may require advice from a licensed professional

Over 65-year-olds

- Who are Medicare eligible may not enroll in individual Marketplace coverage
- Refer them to an insurance agent or SHIP counselor
- Depending on the plan type chosen, Medicare supplement insurance may provide lower cost-sharing than Medicare Advantage plans, BUT Medicare supplement is NOT guaranteed issue, except during the 6 month period after turning 65 (there are a few exceptions)
- Medicare Advantage has an open enrollment period every year: Oct. 15 to Dec. 7

Incarceration and Health Insurance

- *Incarceration* is defined as serving a term in prison or jail
- It does not mean
  - Living in a residential facility under supervision, such as probation, parole, or home confinement
  - In jail, pending trial—not yet convicted
- If you are serving a prison or jail term, you cannot buy private insurance, on the Marketplace or otherwise
- Upon release, the person becomes eligible for coverage and will have an SEP—60 days
- No individual penalty can be assessed during the period of incarceration
- When a person has been charged with a crime, but not convicted, they may access the Marketplace and keep individual coverage
- That person may also be eligible for Medicaid, although Medicaid won't pay for medical care if the person is serving a sentence in prison or jail

The SHOP and Employer Responsibilities

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SHOP Marketplace

- The Small Business Health Options Program (SHOP) is open to small businesses with up to 50 employees, or 50 full-time equivalent employees
- Use the SHOP FTE calculator for a quick way to see if you qualify for the SHOP Marketplace
- For 2014 health plans, employers must sign up with a certified agent or broker or directly through a SHOP insurer (BCBSMT, Co-op, or PacificSource)
  - Assurant is not offering plans in the SHOP
- For 2015 health plans, the SHOP online portal is scheduled to open November 15th. The online function provides a method to contact a certified agent to manage the small business's account online.

SHOP Marketplace (cont.)

- If a small employer has fewer than 25 employees, they may qualify for a small business health care tax credit worth up to 50% of your premium costs
  - Use the SHOP Tax Credit Estimator
- Employers can still deduct from their taxes the rest of the premium costs not covered by the tax credit
- Small businesses can receive tax credits for two years worth up to 50% of an employer's contribution to employee plan (35% for tax exempt small businesses)
- Tax credits are only available if employers purchase through the SHOP
- The "employee choice" option is not available in Montana in 2015

SHOP Marketplace (cont.)

Benefits

- The small employer controls the amount of coverage and the amount paid toward premiums; although the SHOP has minimum contribution requirements
- Small employer can choose from 4 levels of coverage (metal tiers) to find a plan that meets the needs of the business and its employees
- Small employers may start coverage any time - Enroll by the 15th of the month and coverage begins on the 1st of the following month
- No "open enrollment period" restriction

All Employer Requirements

- New Disclosure Requirements
  - Notice Regarding the Availability of Marketplace
    - Distribute Model Notices to employees
    - By October 1, 2013 or within 14 days of hire
  - Summary of Benefits & Coverage
    - Model SBCs available, with instructional booklet
    - Effective first renewal following September 23, 2012
    - Your insurance company will provide the SBC

All Employer Requirements

- Waiting period for coverage cannot exceed 90 days
    - Seasonal (less than 6 months) and Part Time (less than 30 hours) employees may be excluded
    - Effective first renewal following January 1, 2014
- Fully-insured medical plans prohibited from discriminating in favor of highly compensated individuals

Small Employer Regulations

- No requirement to provide coverage
  - Requirement to offer coverage applies only to Large Employers
- Ability to access tax credits through SHOP program
- The definition of small employer changes to 1 to 100 employees or full-time equivalent employees in 2016 by operation of federal law
- Even small employer coverage decisions are complex and best served by a licensed insurance agent
  - Tax consequences also must be taken into account, along with decisions about cafeteria plans and HSAs

Small Employer Health Care Tax Credit

- 2014: Income Tax Credit up to 50% of Premiums Paid
  - No more than 25 full-time equivalent employees
  - Average Annual Wages do not exceed ~$51,000, CPI adjustment
  - Uniform Premium Payments by Employer, not less than 50%
  - The qualified health plan is through the Exchange
  - Must have at least one unrelated employee, family members do not count in the FTE calculation

Marketplace Certification

- HB250 (passed in 2013) created state specific training and certification requirements
- Navigator and CAC Certification page on our website
  - http://www.csi.mt.gov/industry/Navigator_CAC_certification.asp
- Certification is dependent on employment by a CAC Organization or a Navigator grant recipient

Navigators

- Exam requirement at Pearson Vue Center
- Time requirement for fingerprint/background check
- Continuing Education Requirement of 10 hours
  - Check your certification expiration date
  - Affects very few returning navigators
  - Courses must be MT approved CE through CSI
- producerlicensing@mt.gov
- Jeannie Keller, jkeller2@mt.gov

Questions?

1-800-332-6148

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Commissioner Monica J. Lindeen

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